INSTRUCTIONS

CERTIFICATE OF MEDICAL NECESSITY FOR DURABLE MEDICAL EQUIPMENT/SUPPLIES

This form is not to be used for oxygen therapy. For Minor Assistive Devices, Special Medical Equipment and Home Modifications, use GW-SF.

SECTION A : TO BE COMPLETED BY DME PROVIDER

* Enter recipient's full name
* Enter the date this form is prepared (mm/dd/yy)
* Enter recipient's Medicaid identification number
* Enter recipient's height and weight
* Enter DME provider's name
* Enter DME provider's street address, city and state
* Enter name of contact person to call if RI Medicaid has questions
* Enter contact person's 10 digit telephone number
* Enter ICD-9 or ICD-10 code (based on date of service) and description of diagnosis
* Print ordering prescriber's name
* Enter the correct HCPCS procedure code

SECTION B: TO BE COMPLETED BY PRESCRIBER

* Enter prognosis as poor, fair, good. Enter diagnosis
* Enter number of months condition is expected to last. If indefinite, estimate
* Check off the functional level that applies to recipient
* Describe item ordered and explain how particular problem, resulting from diagnosis, relates to requested item
* If supplies are being ordered, please indicate the frequency of use
* Enter number of months item will be needed
* Enter date (mm/dd/yy) of last visit with recipient

Prescriber certification

* Print ordering prescriber's name (must be MD, DO, PAC or RNP)
* Signature must be that of the ordering prescriber
* The date of this signature is also required

Certificate of Medical Necessity is valid for one year